

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____ Date of Birth: ___/___/___ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (____) _____ Alt. Phone Number: (____) _____ Caregiver name: _____

Clinical Information [Attach copy of labs and office notes]

Diagnosis code: M17. _____ Other: _____ Diagnosis: Osteoarthritis of the knee Other: _____

NSAIDs: Active, name and dose: _____ Contraindicated/failed, describe: _____

Steroids: Active, name and dose: _____ Contraindicated/failed, describe: _____

Other pertinent past medical history and/or drug therapy: _____

Weight: _____ kg lb Height: _____ cm in Allergies: NKDA Other: _____

MEDICATION	DIRECTIONS	DISPENSE QTY FOR
<input type="checkbox"/> Gel-One 30 mg/3 mL PFS <input type="checkbox"/> Monovisc 88 mg/4 mL PFS <input type="checkbox"/> Synvisc-One 48 mg/6 mL PFS	Inject 1 syringe IA into <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT knee once (to be administered by healthcare professional)	1 dose
<input type="checkbox"/> Hymovis 24 mg/3 mL	Inject 1 syringe IA into <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT knee once a week x 2 weeks (to be administered by healthcare professional)	2 weeks
<input type="checkbox"/> Euflexxa 20 mg/2 mL PFS <input type="checkbox"/> Gelsyn-3 16.8 mg/2 mL PFS <input type="checkbox"/> Synvisc 16 mg/2 mL PFS	Inject 1 syringe IA into <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT knee once a week x 3 weeks (to be administered by healthcare professional)	3 weeks
<input type="checkbox"/> Orthovisc 30 mg/2 mL PFS	<input type="checkbox"/> Inject 1 syringe IA into <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT knee once a week x 3 weeks (to be administered by healthcare professional)	3 weeks
	<input type="checkbox"/> Inject 1 syringe IA into <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT knee once a week x 4 weeks (to be administered by healthcare professional)	4 weeks
<input type="checkbox"/> Hyalgan 20 mg/2 mL PFS <input type="checkbox"/> Supartz FX 25 mg/2.5 mL PFS	Inject 1 syringe IA into <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT knee once a week x 5 weeks (to be administered by healthcare professional)	5 weeks
<input type="checkbox"/> Other: _____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

Prescriber Information [Ship to prescriber: No Yes, appointment date: ___/___/___] Use Cover My Meds: Yes No

Name: _____ DEA# _____ NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (____) _____ Fax Number: (____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: _____ Date _____
 (stamps not accepted) Substitution allowed Dispense as written/ Do not substitute

For states requiring hand written expressions to prevent substitution, write here:

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